Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name
Travelers Indemnity Co of Conn

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-11-3490-01

MFDR Date Received
June 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…pre authorization number has been located in the appropriate box on the cms-1500 since it's initial faxing. This is evident on all four claims. "

Amount in Dispute: $452.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the Provider failed to properly code the billing submitted to the Carrier, the Provider is not entitled to reimbursement for the billed services. The carrier contends the Provider is not entitled to reimbursement for the billed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17 – 22, 2010	Physical Therapy	$452.00	$53.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out billing requirements for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - TXM9 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. REIMBURSEMENT IS MADE BASED ON MEDICARE CODING, BILLING AND REIMBURSEMENT METHODOLOGIES.

Issues

1. What modifiers are required for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied all services using claim adjustment code TXM9 – "THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. REIMBURSEMENT IS MADE BASED ON MEDICARE CODING, BILLING AND REIMBURSEMENT METHODOLOGIES." Per 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, …"For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing;…" Medicare Claims Processing Manual, Chapter 5, Section 20.1 states, "The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:
   - GN Services delivered under an outpatient speech-language pathology plan of care;
   - GO Services delivered under an outpatient occupational therapy plan of care; or,
   - GP Services delivered under an outpatient physical therapy plan of care.

   This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter."

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.202 to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.

Code	Date of Service	MAR Calculation	Units	Allowable	Carrier Paid
97124 GP	December 17, 2010	36.8729 x 23.87	1	$35.16	$21.67
97032	December 17, 2010	Not eligible for review	1	$0.00	
97035	December 17, 2010	Not eligible for review	1	$0.00	
97124 GP	December 20, 2010	36.8729 x 23.87	1	$35.16	$21.67
97032	December 20, 2010	Not eligible for review	1	$0.00	
97035	December 20, 2010	Not eligible for review	1	$0.00	
97124 GP	December 21, 2010	36.8729 x 23.87	1	$35.16	$21.67
97032	December 21, 2010	Not eligible for review	1	$0.00	
97035	December 21, 2010	Not eligible for review	1	$0.00	
97124 GP	December 22, 2010	36.8729 x 23.87	1	$35.16	$21.67
97032	December 22, 2010	Not eligible for review	1	$0.00	
97035	December 22, 2010	Not eligible for review	1	$0.00	
			TOTAL	$140.64	$86.68

3. The total allowable for the disputed charges is $140.64. The carrier paid $86.68, which leaves a balance due to the provider of $53.96

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $53.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $53.96, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.